Capacity Review Committee

Phase II Stakeholder Consultations

Research & Knowledge Transfer Report

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Bridging Boundaries

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Section I — Project Description

In June 2004, the Ontario government launched Operation Health Protection, a three-year plan to rebuild public health. The goal is a stronger revitalized Public Health system able to meet the population's public health needs. A key component of Operation Health Protection was the formation of the Capacity Review Committee (CRC) by the Chief Medical Officer of Health (CMOH). The CRC is responsible for both analyzing the existing *capacity* of the local Public Health Units (PHUs) to meet their local needs as well as *how* they deliver their services in order to come up with system wide, manageable and sustainable solutions and recommendations. The goal is not to review or assess the operations of any individual PHU, but to analyze and gather data from all PHUs to assess how they can work more effectively as part of an integrated public health system.

The committee will provide advice to Ontario's Chief Medical Officer of Health and the Public Health Division as to how to renew public health in relation to rebuilding public health capacity within the province; enhancing public health leadership and accountability; and, improving system collaboration and partnerships. The CRC is to report to the Chief Medical Officer of Health in the winter of 2006.

In relation to public health services, the content of that advice is to be in the following areas:

- Core capacities required at the local level to meet communities' specific needs and to effectively provide public health services
- Issues related to recruitment, retention, education and professional development of public health professionals in key disciplines
- Operational, governance and systemic issues that may impede the delivery of public health programs and services
- Mechanisms to improve systems and programmatic and financial accountability
- Strengthening compliance with the Health Protection and Promotion Act, associated regulations and the Mandatory Health Programs and Services Guidelines
- Organizational models for public health units that optimize alignment with the configuration and functions of the LHINs, primary care reform and municipal funding partners
- Staffing requirements and potential operating and transitional costs

Extensive consultations with the field have been a critical component of the committee's task. As part of this work, it has established key sub-committees that incorporate community expertise:

- Governance & Structure
- Public Health Human Resources
- Public Health Funding

- Knowledge and Research Transfer
- Public Health System Accountabilities

It has also conducted two major surveys with support from the Strategic Planning and Implementation Branch. The surveys have been distributed and completed by all Public Health Units as well as their staff and board members. A capacity mapping initiative has also been completed by the Ontario Public Health Association which includes selected human resource and training issues. It has received submissions and presentations from individuals and groups with important perspectives on public health revitalization.

The Capacity Review Committee produced and published on the internet in early November 2005 its interim report entitled "Revitalizing Ontario's Public Health Capacity: A Discussion of Issues and Options". In that report it presented its conclusions to date and some of the directions being pursued and options being considered by its subcommittees.

Starfield Consulting was engaged by the CRC in mid October to conduct the Phase 2 consultation with the objective of probing on specific issues identified by the CRC subcommittees given the survey results from Phase 1 and their other research activities. The objectives of the second phase included:

- Conducting a series of interviews and focus groups with health unit staff, managers, leaders, board members and local partners; and
- Conducting three round table discussions in the following areas: Accountabilities, Funding, and Academic and Health Human Relations.

The Starfield Consulting tasks have now been completed through site visits and roundtable events.

Section II — Multiple Reports

Because of the amount of information, Starfield Consulting has produced three reports each focused on a different set of subcommittee questions:

(1) Accountabilities, Funding and Governance,

(2) Research and Knowledge Transfer, and,

(3) Public Health Human Resources.

This report is focused on **Research and Knowledge Transfer.** The kinds of questions posed and the responses received are closely related in these three subcommittees.

The body of this report contains the results of the health unit interviews and focus groups related to the Research and Knowledge Transfer subcommittees. The results of the round table discussions were submitted in separate reports to each subcommittee, and are now included in separate documents to the three main reports.

Section III — Consultation Design and Methodology Overview

Starfield has conducted a series of interviews and focus groups with health unit staff, managers, MOH, CEO, CAO(where appropriate), Board members and local partners to probe on specific issues identified by its subcommittees. The on site interviews or focus groups were conducted between November 1 and November 30, 2005. All 36 Public Health Units were induded in the stakeholder consultations. The initiative began on October 13, initial telephone reports were required on December 5th, a presentation to the CRC occurred on December 15th.

Starfield Consulting put together a team of 9 consultants and a logistics coordinator. Two principal consultants oversaw all components of the project and liaised with the CRC and its representatives. The first and second levels of findings were done by the six field consultants and the final reporting of findings was prepared by the two principal consultants.

The design of the consultations was lead by Starfield's two principle consultants based on the context provided by the MOHLTC Strategic Planning and Implementation Branch leads and staff and the brief interviews with the subcommittee chairs over a two and a half week period. The questions developed were then also reviewed by Dale McMurchy and Dr. George Pasut who made the final decision as to the questions to be asked.

Interview and focus group protocols were developed and approved. Focus groups were designed to maximize participation of management and staff in the short time frame available at each site. A few questions were added or modified to engage the participants and stimulate appreciation for successes and positive accomplishments. A total of 83 questions were included in the whole process. Most questions were targeted and thus only asked of one or some of the groups involved.

There were many open-ended questions leading to a substantial number of responses. Thus, the questions were coded into themes to allow for improved reflection on the data. It was not possible to "prioritize" the data and not appropriate given that we were seeking "top of mind" responses in a variety of ways.

The analysis of the data to support the perception of the findings was based on a maximum of 10 most frequently mentioned themes, if appropriate. Field consultants worked with assigned questions to develop an initial summary of findings. A second level of analysis of findings was a summary focusing more on highlights, emerging issues and polarities when appropriate. The lead consultants reviewed and edited the findings.

Some limitations to our design and methodology

- Protocol questions were developed rapidly and the initial testing done during project implementation. The question development process did not follow rigorous research standards. It could not in the time frame available and that was not the expectation of the CRC.
- Theming or coding of the data generated by the site visits and interviews was completed quickly with limited quality control. There was, however, a general testing of assumptions and highlighting of patterns around demographic cuts.
- Demographic "cuts" of the data were conducted in the analysis. There were some differences in the demographic data provided by the province and the realities encountered in the field, but not time to change the assumptions in the analysis.
- Given that the data recording and transcription was done by six people and that a tape recorder was not used for interviews, the potential for translating the qualitative data into statistically valid quantitative data was limited.
- Because of the tight time lines, theme selection was done after data collection and transcription was completed in 27 of the 36 health unit's so that data entry could begin. Themes might have varied if we had been able to finalize them at the end of the site visits.

The conditions for a valid test for statistical significance of the data are not present.

A more detailed description of the consultation methodology and design is provided in Appendix A of this document.

Section IV — Consultation Findings

Introduction to Consultation Findings

Each health unit in the province took part in the consultation process. The following respondents or respondent groups were involved in the consultation. For a complete breakdown of the health units and respondents involved in the process see Appendix D and **Error! Reference source not found.**.

- An interview was conducted with the MOH. In health units which had a separate CEO or Executive Director role, the CEO or executive director was also interviewed. We were successful in interviewing the MOH and/or CEO from every health unit. The following is a summary of the MOH/CEO interviews conducted.
- Where appropriate the CAO or City Manager of an aligned organization was interviewed. 5 CAO interviews were conducted.
- A group interview was conducted with a cross-section of Board members from each health unit. The health unit and their Boards made the selection of which Board members to include in the interview. A total of 104 Board members were interviewed. Of these Board members, 12 were provincial appointees, 87 were municipal politicians, and 6 were citizen Board members.
- Focus groups were held with both management and staff groups. Health units made the decision as to who was included in each of the meetings. Health units were asked to provide a cross section of participants. They were cautioned to refrain from including managers in staff focus groups in order to protect the confidentiality of these discussions. A total of 585 staff members and 430 managers participated in focus groups. The groups crossed a wide variety of disciplines and represented a wide range of experience. Approximately 30% of the participants had less than five years of service, and just over 25% had over 20 years of service.
- A total of 78 Partner organizations were interviewed. These organizations included 16 school Boards, 15 hospitals, 28 community care or medical companies, 4 charities and 15 other types of organizations.

There were four types of questions asked.

- Most were targeted questions designed to understand participants' views on specific areas of interest for CRC subcommittees. These questions have been synthesized to provide perspectives of the Public Health system as a whole.
- A few questions are focussed on issues experienced by only a handful of health units (e.g. Those who have undergone consolidation). These questions were asked to only the applicable Health Units.
- A few funding questions require detailed information specific to the health unit. This information was collected and submitted separately (a high level summary is included in this report).

- Two questions were included to get an overall sense of the accomplishments of the Public Health system as a whole. A summary of these questions has been included at the beginning of the findings section.

Public Health Accomplishments

Interviews and focus groups generally started with a request for participants to describe what they felt were their top accomplishments over the past year. The following are some of the highlights of these responses.

Most health units were eager to report on 'good news' when asked to cite their recent top accomplishments. Most units mentioned success in meeting the Mandatory Programs and Services Guidelines, (including many unique and innovative approaches to reach, influence and serve their communities), enhancing relationships and community partnerships, meeting local needs, and internal process improvements. Linked to their local successes, many also cited better recognition and profile in their communities.

In addition, those units that experienced physical or organizational restructuring such as amalgamations, internal shifts and/or hiring a new MOH or other senior staff, talked about how they had 'made it through' without major disruptions to the services they provide to the public.

The most frequently cited success was around tobacco policies and programs. A large number of units were proud of their ability to implement 'Smoke Free Ontario', by working with the local municipalities to pass smoke-free by-laws in all public places (and in some units workplaces too). These efforts included long and often painstaking discussion and debate with local municipalities, including many that were, for political or economic reasons, dead set against smoke-free policies. Through their relationships and ability to influence locally, these laws were passed with a minimum of backlash. In addition to the by-laws, many Public Health units were proud of their ability to prevent or reduce tobacco usage by developing and implementing programs in schools, educating and mobilizing parents to influence their children, and by working with corporations to provide access to smoking cessation support and education materials to their employees.

The second most cited success was progress in pandemic planning and emergency preparedness including surge capacity. Clearly this is a response to the recent national and local outbreaks and to the provincial mandate to all communities to work together to develop plans for managing such incidents. The units' partnerships and relationships within their communities were also essential to progress in this arena.

Many were proud of their ability to quickly and appropriately react to local incidents and crises. For example, they cited success with managing illegal meats, the rubella and e-coli outbreaks, arsenic poisoning in a local lake, water contamination incidents, and responding to the cosmetic use of pesticides.

Everyone commented on progress in meeting mandatory programs, including specific examples of increased utilization rates, unique approaches to providing access, enhanced partnerships to influence and reach broader segments of their population, internal programmatic process improvements and evaluation methods and results. Units were

proud of their public awareness campaigns (i.e. Influenza, West Nile Virus) and increased utilization rates (immunization, breastfeeding and Chlamydia clinics, and sexual health services). Many cited either new or ongoing results of programs including: Obesity programs (Healthy Weights and Physical activity programs), Best Start and Healthy Babies (early childhood development), Water monitoring, Eat Smart (including partnerships with farmers on "Field to Table" and "Food Basket") and "Food Check" initiatives (inspections) and "Workplace Wellness".

Public health employees are proud of their positive relationships and recognize the importance of their liaison and connecting role. Numerous Public Health Units mentioned unique and innovative community partnerships to assess and address local issues often 'beyond the mandatory programs'. They are proud of their partnerships with local agencies to help the homeless, train maternity nurses to support and coach new mothers on breastfeeding, reduce violence in schools, prevent teenage pregnancies, help new mothers manage post partum depression, train and support drug addicts in the safe use of needles, assist youth through on-line health information, and plan for urban growth. Their pride is in the impact they are making on their community.

Public health employees interviewed are also pleased with their work on process improvements. Most often cited accomplishments include work on Strategic Planning, followed by achieving accreditation (4 years). Also cited were quality assurance and service improvement plans, operations reviews, more evidence based planning, increased accountability measures and implementing a balanced scorecard approach.

Several units successfully reorganized either through mergers, relocations and/or internal shifts. Two that amalgamated were proud of their ability to do so 'without skipping a beat' and without layoffs. Others that faced such shifts reported on their ability to harmonize wage and union agreements. Also several units were proud of their internal structuring to cross train employees and reflect the social determinants of health model (multidisciplinary teams). They believe the new structure is changing the culture so that 'now people like to come to work'.

Many units reported that, in line with their efforts, they have increased their recognition and profile with the community. They are happy about success in this arena as evidenced by CMOH, positive media attention, recognition through public service and other awards, and, in one case, the public's reaction to their new weekly radio show.

The many examples of successes emphasize the *local* role of Public Health to deal with a *wide range* of issues. Employees are proud of their connections with and their job to serve the community. They feel most successful when they see evidence that what they do does 'promote health' and 'prevent disease' - *in their local community*. This evidence comes in many forms; local population health statistics, local survey results, program usage rates, media coverage and invitations to participate in events, conferences or coalitions addressing local issues. They also noted and appreciated the recognition they receive in praise of their efforts and accomplishments. For the most part, this recognition comes from those they work with and serve.

Section V — Introduction to Research and Knowledge Transfer Questions & Findings

In Phase I of the CRC initiative, the Research and Knowledge Transfer and Exchange sub-committee had identified that local units were actively involved in research and information sharing. They had identified the research priorities for those units and some initial ideas on the strengthening of knowledge transfer and exchange. The subcommittee had also explored the role of the new Ontario Public Health agency and began to explore the role health units could play.

In Phase II, the subcommittee chose to explore what adequate research and knowledge transfer capacity at the local and regional levels might look like. As well, they sought feedback on the supports that were seen to be required from the provincial level. The questions posed are as follows:

- What would adequate research and knowledge transfer capacity look like at your health unit?
- What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?
- What supports for research and knowledge transfer capacity needs to be in place at the provincial level?

These questions were asked in the MOH/CEO interviews and of the Management and Staff focus groups.

Some respondents did raise the question as to what was meant by "research" and "knowledge transfer". In these discussions, "Research" tended to include the whole gamut of possibilities from new knowledge to program evaluation, from scientifically rigorous studies to action or participatory research. Knowledge transfer was a new term for some but the essence of it seemed to be grasped.

The sub-committee also asked for both responses on what adequate capacity looked like and what local units have now. The phrasing of the question and the focus group format did not allow for the more detailed combination of the two inquires. Groups focused more on what "adequacy" would look like based on their local experience. Of course, there were a number of interpretations of adequate.

Participants in the focus groups seemed to learn from each other about their unit's research and knowledge transfer capacity and what was seen as the minimum needed. There was little difficulty in getting focus group participants to develop the initial input into the conversation.

In the second questions, the phrase "regional Ministry health planning level" was confusing for many. Some saw their unit as "the region". In the South West or in smaller units or regions there was more awareness of their health unit planning regions. Others had limited or no experience in their planning region, particularly as staff or managers. This was also true in the North where Regional also meant local and, for some, local does not mean what is referred to as North, it also includes Manitoba.

Findings for Research and Knowledge Transfer

Adequate Local Capacity

When respondents identified what adequate local capacity for R&KT looks like, some similar themes emerged to those in the Interim Report and there were also some differences. Timely access to research and data was the most often stated response for CEO/MOHs and for management and staff. Intentional knowledge coordination and brokering was frequently stated as well as an essential local capacity.

Some particular specialist skills were mentioned by management, and also by MOH/CEOs and staff. Those seen as required in adequate capacity included:

- On-site Epidemiologist
- Surveillance
- Data Analysts, Advanced statistical analysis
- GIS
- Research Nurses
- Health Economists
- Bio-statistician
- Population Health Specialist
- Action or participatory research

The establishment of a strong research and knowledge transfer unit culture, one that supports an evidence-based approach, was also seen as quite important. This was seen to happen best when research and transfer of knowledge is built into the strategic planning process of the unit.

An emphasis that was not as strong in the subcommittee's interim report was that of adequate work time availability. This was a concern of more management staff than others. For some, being overloaded in their work means that research and knowledge transfer becomes less of a priority.

Access to academics and to changed PHREDs, program evaluation and reporting skills, and local research coordination were all part of an adequate capacity for some.

Adequate Regional Capacity

The number of respondents from all respondent groups to this question was less than either the local capacity or the provincial role questions. The primary capacity seen to be needed at the region was that of enabling communication and collaboration across all respondent groups, regions and autonomous or aligned units. Access to data and people

resources at the regional level was also important for MOH/CEO, management and staff responders.

The direction or coordination of research planning and of work at the local unit level also was identified frequently, particularly by MOH/CEOs who responded but also by management and staff. Doing regional research was also seen as an important capacity at the regional planning level, particularly by management responders.

Clarifying the relationship of regional capacity to PHREDs was more of a concern to MOH/CEOs than to either management or staff focus groups, but all mentioned the topic. Timely dissemination of research was mostly seen by staff and management focus groups as a role for the region. Its potential for aiding professional development was identified in all groups.

Provincial Level

Certainly knowledge dissemination was seen to be an important role for the provincial level, particularly by staff and management focus groups. MOH/CEOs strongly identified the role of the provincial level in giving direction, in coordinating and communicating both research activity and knowledge transfer. This was shared almost equally by management and staff respondents.

MOH/CEOs as well as management and staff commented on the role of the provincial level in providing staff support to local units and regions. MOH/CEOs provided substantial critiques of current provincial level staff support and some believed there were not enough "competent staff" members to populate a provincial agency. Others saw that staff members with "super skills", beyond those available in the units, are needed at the provincial level to provide the supports needed. Staff and management, both seek staff support at the provincial level and believe it can be found.

There was strong support for the provincial level doing its own research, particularly related to the mandatory programs and collecting important information from sources outside of the province, such as the CDC. Some emphasized the importance of that research being based on the fields' needs. Funding for local research was also desired as was the coordination of the technology capacity across the province. Provincial portal to data, the development of appropriate software, user groups for certain tools for research were all seen as part of that role.

The direction from the provincial level must also include setting the accountability frameworks, the standards, for developing measures and research. This allows for accountability frameworks for all initiatives to be developed. Another important role for the provincial level is to support the regions, and any groupings, networks or gatherings that assist with research and knowledge transfer.

At both the provincial and the regional levels there was a strong desire of all respondents that research priority setting connect to unit and front line needs and that there be involvement throughout the system in setting priorities.

Questions and Findings — Research and Knowledge Transfer

26 **QUESTION:** ***What would adequate research and knowledge transfer capacity look like at your health unit?***

QUESTION CATEGORY	Research and Knowledge Transfer	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	R & KT		
		RESPONDENTS	MOH/CEO	√	Yes
			Board	×	No
			Management	√	Yes
			Staff	√	Yes

Description of Themes

Theme: Timely Access to research information and data

For the largest number of respondents having access to information and research data that relates to the Public Health issue being addressed in a timely way was a requirement for an adequate capacity. This included the largest number of staff and MOH/CEO responders and the second largest number of management responders in any theme. To all groups this meant having IT access to data bases that were both internal and external to the unit. Responders believe they require real-time internet connections that are seamless. IPHIS was mentioned as a step in that direction and Tele-health as another example. As one MOH/CEO stated, "we should not have to be searching for things" at the local level.

Both management and staff saw the need for field devices that would allow for access to critical information including GPS data. The information used locally also includes census data, hospital administration, health indicators, chronic disease information and mortality data. Program research data tailored to program delivery and translated into best practice was also a key for some staff and managers.

Being adequate also includes access to complete data bases, for example: Manitoba health or First Nations' data or regional and local health status information.

Theme: Knowledge coordination or brokering

IT access to the data was not sufficient for adequate capacity for Staff, Management or MOH/CEO responders. They also saw the need for access to a dedicated reference librarian or a person playing the role of knowledge coordinator for the unit. Someone who would actively disseminate knowledge to management and staff give assistance on access to journals, or support a research room. The dissemination and communication of knowledge was seen as inexorably bound to the teaching role in a local unit by a management responder.

All groups saw the need to be able to coordinate knowledge with other health units (and this is emphasized by the responses to the next question). Regular meetings and web interaction were identified by respondents in each group as well.

Theme: Research Specialist Skill Sets: 4

Management focus group participants gave the largest number of research skill set responses, but the following skills were mentioned by all three groups of respondents.

- Onsite Epidemiologist
- Surveillance
- Data Analysts, Advanced statistical analysis
- GIS
- Research Nurses
- Health Economists
- Biostatistician
- Population Health Specialist

Having on site those skilled in the new ways of doing research such as action research or participatory research was a required capacity for management from at least one unit.

Theme: Culture supporting evidence based programs

Adequate capacity for a large number of responders from MOH/CEO, staff and management groups includes having a unit culture that supports an evidence based approach. As one MOH/CEO said, we "need a core Public Health workforce that has core competencies to do this work". In an adequate culture, staff and management make use of research. According to a management focus group, we "close the loop".

When there is sufficient experience and knowledge as to how to use the research its dissemination will be valued. Programs then are evidence based, according to a staff respondent. A management respondent stated that this happens best when research needs are built into the strategic planning process.

Theme: Ongoing Professional Development 2

Again a large total number of respondents, but fewer MOH/CEOs, stated that ongoing professional development is an important aspect of adequate capacity. One time professional development is not sufficient given the changes in knowledge. MOH/CEO respondents saw the advantage of on-line courses and certification. Staff and management suggested a number of similar items to those considered for professional development in the human resources section. They saw the particular need for the use of these approaches for research and knowledge transfer development. They mentioned approaches such as were suggested as part of such ongoing development: in-services, webinars, mentors, preceptorships, involvement with their professional associations or secondments to other institutions such as school Boards, hospitals, labs, universities and colleges. Such ongoing development or training will need to take into account geographical differences between units.

Theme: Work Time Availability

Adequate time to devote to either research or knowledge transfer was also seen as a requirement for adequate capacity by a substantial number of respondents. Management respondents identified this capacity most frequently and it was a stated concern for few MOH/CEOs. However, one MOH/CEO stated that she/he had "no time to read research and apply it". Management and staff responders echoed the importance of time to expand their knowledge by reviewing and reading research. Some believed that time should be protected in their job descriptions and others saw the need for more program staff that would allow for the time in their work schedule.

Theme: PHRED and Academic Access

A smaller number of respondents, with the largest representation being from MOH/CEOs and Management, also saw a local capacity requirement as access to external academic or PHRED like services. As one MOH/CEO respondent said, the "PHRED program hasn't worked very well in terms of transferring information out" to us locally. The most useful approach for us "was the Health Intelligence Unit which got nixed last year". A management respondent stated that he/she missed the HIU. Some Management and staff want formal links with research groups in universities. One MOH/CEO respondent provided a contrary point of view and said, "Leave the research to the universities."

Theme: Program Evaluation & Reporting Capability

Although there were not many comments elaborating on the capability all three respondents mentioned the importance of program evaluation and reporting. For one MOH/CEO, this capability is based on current best practice research and for a management respondent on local best practices being established.

Theme: Local Research Coordination

In addition to coordination of local knowledge transfer, all three groups of respondents saw the important of local research coordination for adequate capacity and had similar responses. Local policies and procedures with regard to research are required including a process for ethics review. A research room has helped in some units with good administration support. This can be supported by local communities of research practice grounded in the local culture and issues. It is supported by services for research information management such as literature searches, cataloguing and IT support. Such coordination would need an understanding of research methods

27 **QUESTION:** ***What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?***

QUESTION CATEGORY	Research and Knowledge Transfer	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	R & KT		
		RESPONDENTS	MOH/CEO	√	Yes
			Board	×	No
			Management	√	Yes
			Staff	√	Yes

Description of Themes

Theme: Regional Communication and Collaboration

The capacity for regional communications and collaboration or regional networking was seen by at least one respondent from all Public Health regions as an important part of knowledge transfer and exchange. Both MOH/CEOs and Management respondents saw such collaboration following the Health Intelligence Unit structure with a council or body that brings together health unit representatives together with others such as LIHNs, Family Health Network Representatives or academics to interpret health information and to inform health research planning.

Respondents identified various types of networking or collaboration including face to face meetings, video conferencing and web sites for exchange of information. A management respondent saw the possibility for regional collaboration on RRFFS. Such regional efforts could also play a supportive and facilitative role to research questions generated at the local level.

For Staff, Management and CEO/MOHs access to universities and colleges is part of that regional capacity. It would include both relationship with universities and links to research students.

Theme: Access to resources

Adequate research and knowledge transfer at the regional level goes beyond networking for some MOH, Management and Staff respondents. It includes providing access to both data and people resources at the regional level. Substantially fewer respondents from aligned units mentioned this role as regional level capacity to be considered. As well, the preponderance of responses (90%) came from units of population size less than 299,999.

Some staff respondents believe that regionally gathered data can be shared, like regional population data, along with technical support being provided. Key advisors or PHRED advisors in the region could be shared to support local or regional initiatives. A resource like the Northern Virtual Library could be accessed by others than just registered health professionals.

An MOH/CEO respondent saw the possibility of sharing risk communication and communicable disease experts at the regional level. Manager focus group respondents saw the advantage of sharing "who is doing what research" to provide better access to resources.

Some Management respondents saw the possibility that regions could have access to more money for research and knowledge transfer.

Theme: Direction/Coordination re: Research

Almost an equal number of Staff, Management and MOH/CEO respondents saw the region as directing as well as coordinating research across health units in a region. Again there were substantially fewer comments from aligned health units on this topic and almost 75% were from units with less populations less than 299,999.

The regional capacity, according to one MOH/CEO would include defining expectations for such research and establishing measures to ensure it happens. Another assumes it would not be purely academic research.

Management respondents want a regional capacity to include preparing statistical reports at a broad level and assisting with data manipulation and cleaning. A region would also link both to relevant Ministries and to the provincial level agency. It would identify research strategies and best practices and translate those to the local level. Part of a regional mandate should include building local capacity at each unit, by developing training on new techniques, databases, computer support and provide a help desk function.

Staff also saw the need of a region to assess local needs and develop decision making frameworks for research based on best practices. In order to move in this direction, a management respondent saw the need for the region to operate under a provincial mandate with clear terms of reference, provincial support and funding

Theme: Regional Research: Planning & Priority setting 7

For some respondents, regional capacity includes the carrying out of regional research initiatives. Management respondents mentioned this more often as did respondents in the Eastern Region. MOH/CEO, management and staff respondents saw such initiatives linked to teaching hospitals. Management respondents saw regional research as consistently planned with issues common to units, and possibly linked to a local unit. Such research could help "fill in the gaps". Another person suggested considering grouping such research by distinct communities rather than geography.

Some Manager respondents also suggested that part of the planning would include a regional coordination of ethics approval for research.

A number of caveats to such regional research were also voiced by Management. Some have found priority setting at the regional level "horrendous". Another was concerned that regional research would be so broad as to not be useful to units.

Theme: Relationship to PHREDs

The mention of needed regional capacity brought up the PHREDs for all respondent groups, with more comments by MOH/CEOs than others. MOH/CEO respondents stated that PHRED was not working, a good idea in theory but the wrong model, and that it was "not designed to succeed from the beginning". However, some were clear that a PHRED like capacity is needed.

One Management respondent mentioned the PHREDs and then asked, "What do they do?" Another was clear that partnering with academics and the LHINs was important and having PHREDs focus on Northern units was worth considering

Staff respondents were less critical but stated that PHREDs needed to be better defined and regional. It does not have a regional mandate and needs stable funding to support research. Some staff respondents saw a regional role for a PHRED like effort where there was more access by all units and increased support for its role.

Theme: Timely access to or Dissemination of Research

One MOH/CEO respondent and some management and staff respondents see the regional health planning level as a place to communicate influential research findings, for effective knowledge transfer. Management respondents see it as a place to synthesize and communicate information that is similar for multiple units. This may involve the development of a regional dissemination plan that is based on benchmarking across health units and best practices. One staff respondent believes that such knowledge transfer mechanisms need to be "organized, inclusive and participatory". Certainly a web site with a data repository is necessary for such dissemination as stated in earlier themes.

Theme: Professional Development

MOH/CEO, management and staff respondent all saw the Public Health region as a potential location for training with regard to research, knowledge transfer and exchange. It could also foster sharing of research among professional groups. Its forums for knowledge transfer could include conferences (video and other) and newsletters.

28 **QUESTION:** ***What supports for research and knowledge transfer capacity needs to be in place at the provincial level?***

QUESTION CATEGORY	SOURCE CAPACITY REVIEW SUB-COMMITTEE:	R & KT		
	RESPONDENTS	MOH/CEO	√	Yes
		Board	×	No
		Management	√	Yes
		Staff	√	Yes

Description of Themes

Theme: Timely and user-friendly dissemination of information

The largest total number of responders saw knowledge transfer supports as a primary function for the provincial level. Staff and Management focus groups were the largest responders in this area. MOH/CEOs had a much larger response to the next themes.

The MOH/CEOs who did respond saw value of provincial dissemination of information related to teleconferences based on research utilizing hard to collect or report information. They saw IT infrastructure as also key to this role, which needs to include data for vital statistics.

Managers saw the province developing a data base of best practices, current research on the best data to collect, data collected on local health indicators, especially chronic disease and surveillance and survey results from a centrally funded RRFFS. Some believed the provincial level would need multiple data bases including its own to draw upon and a centralized reference library to hold information. At least one management respondent saw the need for a mechanism for having grey (not published) research being distributed among the health units. Another believed the Northern Virtual Library should include access for more than just registered health professionals.

Staff respondents made the most comments about the need for a user friendly provincial research and knowledge transfer web site providing access to knowledge resources, data analysis and conclusions – a one-stop resource for Public Health staff. It needs to have both qualitative and quantitative information prioritized by program. A staff respondent also proposed that the site proactively distribute important information based on new research results such as those related to the bird flu. It will also need to distribute program specific information to local units and expedite the information in critical situations.

Theme: Communication & coordination from Province

More MOH/CEOs responded in this theme area than in any other for this question as to what needs to be put in place at the provincial level. Both staff and management focus groups had a substantial number of responses in this area as well.

Some MOH/CEOs emphasized the need for guidance or direction on what needs to be studied. Some see the province as defining needs and priorities, common issues across the units and best practices for moving forward. Some also see provincial leadership being given to establishing a clearing house for knowledge and developing innovative practices and programs that work.

MOH/CEOs see this requiring better communication. They see it currently coming from many sources and departments or from COMOH or alpha.

Management respondents also see the need of provincial strategy and priority setting, but also want transparency in that decision making. Some respondents believe there needs to be both a clear statement of provincial direction on Public Health and the encouragement of innovation and flexibility. This would include a clearer relationship with the e-health strategy and PHIIT. Management respondents are looking for position statements and a clear champion for Public Health research and knowledge transfer.

A staff focus group member added to the role of the provincial level cross-ministry communication with a legislative frame work to support research into key areas like groundwater. Staff respondents also believe in clear and easily accessible provincial standards for data analysis. More coordination between various ministries is also important to some.

Theme: Provincial Staff support PHU

MOH/CEOs also thought it quite important that the provincial level provide staff support to the units. Staff and management respondents also gave a substantial number of responses in this area.
A number of MOH/CEOs expressed their concern over the current provincial staff support in research and knowledge transfer which was described as "no contact, not helpful, poor attitude". One believes there is not currently a provincial staff member who researches a question and then gets the information out. Another stated that there were "not enough competent staff in the province to populate a provincial agency".
There were real differences of opinion among MOH/CEO responders, however, one saw the provincial staff as a potential source of expertise. Some did believe that staff members with "super skills" are needed such as "high level field epidemiologists". Toxicologists and infectious disease specialists who could act as mentors for local staff were also mentioned. Other CEO/MOHs stated that the province needs to skill up first on new and emerging issues and then transfer the knowledge. One suggests that such staff be co-located across the province.

Management focus group respondents also saw the need for such staff support and expertise at the provincial level. One believes that such staff "should be facilitators not barriers" to research and knowledge transfer. Another stated that such staff could collect, compile and analyze data needed to support Public Health programs. Some saw particular support being helpful in high level epidemiology, bio-statistician, program evaluation, risk communication and knowledge transfer.

Staff focus group respondents also saw the value in provincial staff providing guidance on specific issues. One hoped such advice would be available 24/7. Another hoped that the province would "attract and retain big minds". Staff saw roles similar to those of

Management but added that the expert support could help to integrate findings into local programs.

Theme: Strong research to support mandatory programs

Staff, Management and some MOH/CEO respondents are looking to the provincial level to provide particular research support to mandatory programs. MOH/CEOs want such research to set benchmarks and show trends in mandatory programs. Another believes that there is a big deficit in Canadian Public Health research compared to that in the USA.

Management focus group respondents saw advantages to the provincial level being able to carry out research that does not require municipal approval. Strong research at the provincial level is seen to include links to indicators, simple form, systematic literature reviews, statistical reports at a broad level, best practice research. Some see advantages to centralizing RRFSS and the Community Health Survey.

Staff who responded to this item saw the need for the provincial level to evaluate the programs that impact all health units and then revise the mandatory guidelines. Some see the provincial level as a location for gathering and analyzing all national data, provincial data and research.

Theme: Funding for local research and implementation

Staff and Management focus groups most frequently stated their belief that the provincial level should provide funding for local research. A few MOH/CEOs identified this direction, but most did not. One commented that "PHRED should be provincially" funded.

Management respondents saw the provincial level funding research and implementation of research projects given that they see their own time as limited and thus other research planning and development resources are needed. Another management respondent stated that he/she "needs incentives to participate in such research". One management respondent echoed the MOH/CEO to move PHRED funding to the provincial level.

Some staff focus group participants also saw the need for funding for research from the provincial level. Such funding could help staff to adapt provincial research for local planning. It could also encourage local research and best practices. Such funding could aid in subscriptions to journals and in providing additional support for partner agencies in research projects.

Theme: Coordinating Technology Capacity

Even fewer MOH/CEO respondents mentioned the provincial level role in coordinating technology capacity. However, it was a substantial concern for Management and some staff respondents. MOH/CEOs saw the possibility of the provincial level providing web based teaching and sharing of ideas with regard to research and knowledge transfer. One saw the possibility of the provincial level creating systems and support that allow data collection and sharing of results.

Management and Staff focus group respondents saw a number of ways the provincial level could support research and knowledge transfer. Developing appropriate software was one. Another was to develop user groups for particular research tools, such as SPSS, GIS and VPN. Like one MOH/CEOs, some saw a provincial infrastructure and portal with access to collective data and knowledge

Theme: Research based on field needs

Some MOH/CEOs were concerned that the provincial level research needed to be based on the needs of the field, be applied research. This requires input of health units into the research agenda. For another it meant that the research and knowledge transfer "make a difference with staff performance and Public Health – not just be theoretical"

Both management and staff with responses in this category shared the need to focus on applied research and understanding the needs of front line staff. Such research needs to be proactive and create a "greater understanding of community, demographics and trends" according to one staff respondent.

Theme: Accountability frameworks for projects and for all initiatives

Some MOH/CEOs and management respondents saw the provincial level setting the frameworks. For some MOH/CEOs this means setting the accountability frameworks, the standards, for developing measures. For Management respondents it also means developing a continuous improvement loops for knowledge transfer. The best practices developed need to be grounded in local practice. The staff who responded saw the need for local input into such frameworks.

Theme: Provide link and coordinate access to important external research

The provincial level needs to provide access to sources of research outside of Ontario. Some MOH/CEOs tend to call the CDC in Atlanta if he/she has questions. Others want a clear link to PHAC (Public Health Agency of Canada) data. Some managers and staff see a variety of external to the province sources for research on both the determinants of health and treatment of chronic diseases.

Theme: Support Regional Grouping Committees

Some MOH/CEOs, management and staff see a key role for the provincial level to be that of networking among regional centres. It also has a role in helping those where networks are not currently available, to connect to a network. One staff person saw the provincial level making links between PHREDs, provincial research and local needs.

Appendix A Consultation Design and Methodology

Phase 2 of the Capacity Review Committee's work entailed a series of interviews and focus groups with health unit staff, managers, MOH, CEO, CAO(where appropriate), Board members and local partners *to probe* on specific issues identified by its subcommittees based on the information that had emerged during the Phase 1 survey and their other research activities. The objective of this phase was to gain a deeper understanding of the current issues faced by local public health units and understand their current capacity so as to further inform the work and recommendations of the five CRC sub-committees. The evaluation was conducted between October 13 and December 15, 2005. All 36 Public health Units were included in the stakeholder consultations The list of health units consulted can be found in Appendix D-Table 12 - Detailed PHU Demographics on page 45

Consultation Team

Starfield Consulting put together a team of 9 consultants and a logistics coordinator. Two principal consultants oversaw all components of the project and liaised with the CRC and its representatives. They were assisted by four other team members during the field consultations. These six consultants were then supported by three data management assistants to do the compilation and summarizing of data. The first and second levels of findings were done by the six field consultants and the final reporting of findings was prepared by the two principal consultants.

Design of the consultations

A one-day briefing meeting was held in mid-October with six of the Starfield team members. The purpose of the meeting was to review the project intent and deliverables, and provide context on each of the areas that the five CRC sub-committees were interested in exploring.

Starfield's two principle consultants then met with chairs of each of the sub-committees and the SPIB assigned staff person to clarify their lists of questions. In the one-half to one hour meetings, Starfield asked the subcommittee chairs and staff to clarify their intent in asking the question, and the wording, length and their identification of targeted respondents (which respondent group has expertise and context to provide the most meaningful and useful information). The questions developed were then also reviewed by Dale McMurchy and George Pasut who made the final decision as to the questions to be asked. Some questions were eliminated and others revised based on the priorities of the CRC research and available time for the consultation at each public health unit.

Some questions were asked of only one respondent group while others were asked of multiple groups. If a question was asked of multiple groups it was often framed differently in order to add clarity for that specific group. It was expected that Starfield would undertake one or more meetings/ interviews with all public health units in Ontario and that medical officers of health and boards of health would be included in these as well as others on an as needed basis. After consultations with the subcommittees, it was decided that leadership (CEO, MOH, CAO, Commissioner of Health and others), board members, management and senior professionals, staff and partners would be consulted in all public health units. Starfield's proposal for the work was that there would be one day on-site visits. Given the number of stakeholders, a proposed schedule for the interviews and focus groups was developed and confirmed. It was agreed that interviews with partners would be conducted by phone.

Each health unit was sent a letter from the Executive Lead, Public Health System Transformation explaining the purpose of the stakeholder consultations as engaging with health unit executive and staff, Board members and local partners for guidance, advice and feedback on public health policy and planning issues within the CRC mandate. The letter also introduced Starfield and requested that a date during November be identified for the on-site health unit consultation process; that a contact person be identified to be the point person to help arrange the visit and to provide support to the Starfield facilitator while on-site; and to contact Starfield by phone as soon as possible with this information.

Consultation Tools

Interview and Focus Group protocols

Draft protocols for the interviews and focus groups were developed based on the approved questions and respondent(s). Leadership, board members and partners had interview protocols and management/senior professionals and staff had focus group protocols. The reason for the two types of protocols was to accommodate difference in numbers between the respondent groups. There were four types of questions asked.

- Most questions were designed to understand participant's views on specific areas of interest for CRC subcommittees.
- A few questions were focused on issues experienced by only handful of health units (e.g. those who had undergone consolidation within the past ten years). These questions were asked to only the applicable Health Units. A general summary was done for these questions.
- A few funding questions required detailed information specific to the health unit. These questions were sent to the health unit prior to the consultation and prepared answers were collected during the MOH/CEO interviews. The health unit responses have been submitted separately and a high level summary is included in this report.
- Two questions were included to get an overall sense of the accomplishments of the public health system as a whole. A summary of these questions has been included at the beginning of the findings section.

Questions were sorted for appropriate flow to better engage conversation and cover similar topics at one time. This was seen as a necessity because of the overlap in interests between some of the subcommittees' questions. In addition, a suggested on-site agenda and health unit instruction sheet was created (see Appendix H)

A total of 83 questions were included in the data collection process. The CAO and MOH/CEO respondent groups were asked 34 questions; Management and Senior Professionals were asked 33; Board members were asked 32; and staffs were asked 21. Up to three partners per Public Health Unit were also interviewed and they were asked ten questions each. All questions were coded and entered into an excel spreadsheet. A master list of questions and respondent lists of questions were created. See 0 for the master list of questions.

During the first week of November, the overall agenda and question protocols were trialed at four PHUs: Chatham- Kent; Haliburton, Kawartha and Pine Ridge; Grey Bruce; and Waterloo. These initial sites were selected based on their availability within a short lead-time. They also covered a reasonable representation of the demographic interests for the overall system (autonomous/aligned, size, region, leadership, and MOH status).

Based on the feedback from these sessions, some changes to the flow of protocols were made. As well, a triaging of questions for the Medical Officer of Health (MOH) and the Chief Executive Officer (CEO) was done to better distribute leadership questions when there were separate CEO and MOH interviews (one hour allotted for each was not enough time). The redistribution was based on who had the most context to provide meaningful responses. Given the time constraints the information collected from these first units was included in the findings.

Limitations of the protocols

The trial and adjustment of protocols was not intended to be a rigorous field testing of the questions as this was not possible given the timelines for the project. This was considered acceptable given the open-ended nature of the consultations and the type of reporting of findings that had been agreed to during the contracting process.

The development of questions did not follow rigorous research standards. A number of questions were not clearly separated out as two-part questions. Others did not give enough context to ensure comparable responses. And a few were leading questions. Question codes were assigned after field consultations began.

Coding template and theme sheets

All questions were open-ended and generated a tremendous amount of data. In order to manage the volume and type of data that was being gathered, a coding template was developed. Coding is the process of breaking down data into concepts and categories. Open coding involves detailed reading of interview transcripts and the identification of concepts (key words, succinct examples and quotes), which are then grouped as categories (themes). Theme sheets were developed as the tool for the open coding data analysis.

The coding template was based on the type of analysis that had been requested of Starfield: a reporting of themes, patterns, and trends seen in the data. See Appendix I for a copy of the coding template tool, which was produced in Microsoft Word. The template was designed to link locations where theme descriptors appear in the responses and to include descriptors to ensure that themes were well understood. All themes and descriptors within a response were recorded so that for some locations, opposing themes could be included. It also meant that no level of prioritization could be attributed to responses, which is also a function of the questions asked. What could be seen through this analysis was how often an idea was raised. This could be considered a type of priority but should be considered more of a **"top of mind"** response. Questions would have needed to be framed differently and design of the consultations changed had priorities been sought.

A theme sheet based on the coding template was generated for every question. Questions that were shared between respondent groups were first themed independently. During the first round of data entry into the theme sheets all relevant quotes, key words and succinct examples were captured for all themes. Interview notes from nine health unit's (Chatham-Kent, Durham, Grey Bruce, Halliburton, Kawartha & Pine Ridge, Lambton, Niagara, Perth, Waterloo, Wellington-Dufferin-Guelph) were used in the first round.

The themes and key ideas were then quickly reviewed for each of the theme sheets. For those questions that were asked of multiple respondent groups, the theme sheets were compared and harmonized (same theme sheets created across all respondent groups). No data was discarded during this process; however, it became apparent that the use of theme sheets was not possible for all questions. Some questions generated minimal data while others generated long laundry lists so that approximately 50% of the questions were themed.

This first set of harmonized theme sheets was then used for data input for the next 18 health units. After data entry into the sheets was complete for this set of interviews, the "top" themes were identified. As the work on identifying "top" themes was being done, some inconsistencies in theming were noted and a number of questions were re-themed to address this. Again, the first set of harmonized theme sheets with the exception of the re-themed question sheets were used for theming the final nine health unit's.

A total of 26 theme sheets were developed for MOH/CEO questions; 34 for Board questions; 29 for Management and Senior Professional questions; and, 14 for Staffs questions. For those questions that were asked of multiple response groups, theme column is identical for respondent groups; location and description or keyword columns are not, although description columns are similar because they represent the different stakeholder perspectives on the same theme.

Limitations of the theme sheets

Many people were involved in the development of the theme sheets allowing for a richer but probably less consistent coding of the data. The very aggressive consultation schedule did not permit a rigorous level of quality control. It did, however, allow for a general testing of assumptions and highlighting of patterns around demographic cuts.

Demographic cuts

Although it was possible to identify some of the demographic interests of the CRC subcommittees by reviewing the approved questions, Starfield requested that the demographic foci for the data reporting process be confirmed on November 6. The final cut for the demographics was given on November 11 and included a cut of: 1) autonomous or integrated, 2) combined or separate MOH/CEO; 3) filled or acting MOH, 4) size of PHU and 5) PHU region. Toronto was included in the Central East region to preserve confidentiality. In addition to these five cuts, there was a potential sixth cut, depending on how many respondent groups were asked the same question. Numerical codes were used to identify demographic differences. Each health unit was assigned a location code and with the exception of the respondent codes that changed depending on which respondents were asked a question, all other related demographic codes were linked to each location code. Appendix D Table 3, Table 4 and Table 5 contains the demographic listings.

Limitations of the demographic cuts

Demographics were based on the Province of Ontario Public Health Unit Demographic Data sheet forwarded to Starfield for briefing purposes and what was recommended be used for development of the database. During the preparation of demographic lists for the consultation, it was noted that there were differences in the information reported by health unit's on Acting and filled MOH positions compared to the information used for constructing the database. Given the short timelines and the need to start the data entry before the consultation phase was complete, the information provided by the Ministry (rather than the information collected in the field) was used for the analysis.

Information Collection

One consultant conducted a day long process at each health unit. During that day the MOH (and the CEO if separate) were interviewed for up to 2 hours. In aligned units the CAO, City Manager or equivalent was interviewed for one hour. A management and senior professional focus group was conducted over 2 hours. A staff focus group was run for 2 .5 hours. And a group interview of board members was conducted over 1.5 hours. If needed and to accommodate people who may have to drive long distances, both videoconference and teleconference participants were included.

Focus groups were designed to gather the greatest amount of data in the shortest period of time. Participants were asked to divide into five groups for the first hour and to write up their responses onto flipcharts. This was a brainstorming and not a consensus or prioritization exercise so opposing ideas were included and ideas only appeared once even if they may have been considered by many. Responses during group interviews were also handled in a similar fashion with all ideas being recorded and respondents encouraged to not repeat ideas that had already been covered as the time for questioning was very limited.

The second hour of the focus group was spent as a large group reviewing and adding to flipchart responses. There was also a prioritization exercise that was done for many of the questions. After consultation with CRC representatives, it was decided that there was no need to include this information in the interpretation of findings.

Responses for interviews were recorded based on field consultants' preferences; some took handwritten notes and transcribed them later; while others typed notes into a laptop during the interview. Responses for focus groups were taken from flipcharts. After each site visit, approximately 30 – 40 pages of interview and flipchart notes were typed and forwarded to Starfield resulting in approximately 1,500 pages of transcribed data after the partner interview notes were added.

Health units made the decision as to who was included in each of the meetings and were asked to provide a cross section of participants for each of the focus groups and board group interview. Instructions were given to refrain from including multiple respondent groups within a meeting in order to protect the confidentiality of these discussions. All participants were guaranteed confidentiality, in that no names would be used in for the report, nor titles or examples that identify an individual.

The MOH was asked to provide the names and contact numbers for three partners to be interviewed separately by phone and at another time. Although it had been planned that there would be three partner interviews for each health unit there were some partners that could not be reached within the short timeframe allowed for data collection.

Limitations of data collection

Given that the data recording and transcription was done by six people and that a tape recorder was not used for interviews, the potential for translating the qualitative data into statistically valid quantitative data was limited. As well, the limited time set for each meeting sometimes required omitting questions so not all respondent groups were asked all questions; fortunately, this did not happen often.

For the most part, the interview and focus group protocols were followed in the same manner at each site. However, there were several anomalies because an adjustment needed to be made to meet the needs of the health unit. For example, in several situations no board members available on the day of the consultation so interviews were conducted by conference call after the site visit. There were several sites where the consultation was done over two days, either to accommodate the health unit's or the consultants' scheduling needs (complexity of travel often influenced this adjustment). There was one site where the Board and MOH insisted on a joint interview, and another site where the MOH and CEO observed the board interview prior to their separate interviews. A few MOH interviews were done by phone. And several interviews exceeded or did not meet the minimum/maximum number of suggested participants.

The potential impact of this process affected responses in that they were sometimes given based on individual agendas rather than questions asked. In other words, the same answer was given regardless of the question asked. This was most often encountered during the Board member interviews.

There was an inconsistency in preparation for consultation days. The CRC Interim Report was posted on November 2 in the evening, which did not allow for the first health unit to review the report prior to its consultation day. It is also unlikely that the next three health unit's had a chance to adequately review the report before their consultation day. The interim report provided an excellent context for understanding protocol questions and as the consultations progressed it was found that respondents had reviewed the interim report as preparation and that this helped to inform some of their responses.

Data management

Confirming the Analysis Plan

The first round of "theming" helped to identify questions where no patterns or trends seemed to be emerging and which would need other approaches for managing and reporting findings. A CRC update meeting was held on November 16 and requested that some changes to the data collection and reporting processes be made.

At this time, questions were being themed and coded for a systemic summary of interview results. Non-attributable quotes or respondent group queries were not part of the original analysis plan. Starfield suggested that a revised plan be produced describing how data from different questions would be treated. It was agreed that there be a review with the executive lead and an increased analysis for certain questions was deemed appropriate given the results to date.

As well, the next week was spent confirming and refining the level of data analysis required for each question. The final analysis plan can be found in Appendix J — Data Analysis Plan

Theme Selection

In general, it was decided that a maximum of ten themes would be used for the demographic and respondent analysis. It was felt that ten would generate enough of an array of information to be considered for this part of the reporting of findings. No themes were eliminated from the overall discussion of findings since the theme sheets were used along with the response frequencies to frame and inform the interpretation of findings.

Some questions did not have as many as ten themes; these questions were usually associated with a single respondent group. For these questions all themes were used. Other questions where seven or eight rather than ten themes are reported is because the next 4-5 themes had the same number of responses and many were associated with only one or two locations. In this case, these themes were not included in the demographic analysis. The questions and most commonly cited themes were entered into an excel spreadsheet. Numerical codes were assigned to themes for each question code.

Limitations of theme selection

Theme selection was done after data collection and transcription was completed in 27 of the 36 health unit's so that data entry could begin. The final ten health unit's consultations were being done November 25-30. Starfield was requested to provide initial results to the CRC subcommittees December 5, five days after the last consultations. In order to meet this request, data entry needed to begin before the consultation process was completed. It is possible that some of the themes included in the ten may have changed slightly if it had been possible to wait until the completion of the consultation process. Similarly, had only five themes been used for this process, it is likely that no changes would have occurred with the addition of the data from the final health unit consultations. Because the intent of the discussion of findings was to give as rich an overview as possible and because all themes were accounted for in the overall discussion, the use of ten themes for the demographic analysis was maintained. Response rates for the themes should be considered as a general indication of what is top of mind around the issues of concern to the CRC committee.

Data entry and analysis

An excel spreadsheet was designed for data entry. Manual entry of numerical codes was done for location, respondent, question code and theme. Demographic codes linked to each location through formulas (governance, size, leadership, region, MOH status) automatically filled. Data was read from concatenated theme sheets. The final database contained close to 8,000 rows of data.

All fields in the database were translated into numerical entries and then transported into SPSS. Although it was recognized that SPSS was a much more powerful statistical analysis tool than needed it was the program that was most readily available to Starfield and had the capabilities to perform the simple response rate queries needed for the discussion of findings. Cross-tabs were run for all questions based on all demographic cuts. Results were reviewed for only those questions that were identified in the analysis plan. Differences in response rates were used as an indicator to go and more closely review data from the interview notes and report findings accordingly.

Interpretation of Data

Levels of Analysis

Field consultants individually worked on assigned questions and prepared a first level summary of findings. Depending on the question and responses available, the summary took a variety of forms. For some, only quotes and succinct examples were used. For others a listing of types of responses was reported. For others, where the demographic tables were available, these were used to frame the analysis. The first level of analysis was documented and then used to produce a second level of analysis.

The second level of analysis shifted from reporting findings to describing patterns, highlights, emerging issues and outstanding polarities. It was also possible that none of

these were present in the findings and interpretation of this was also done. The second level of analysis was also documented.

Both levels of analysis were shared with team members who gave feedback on areas where they thought more exploration of the qualitative data or interpretations should be done. This is what was used to provide feedback to the CRC subcommittees.

Report Compilation

The two principal consultants used the first and second level findings combined with the feedback from the six facilitators to prepare an initial draft of the final report and a presentation to the CRC committee which was given on December 15, 2005.

The initial report findings section was over 200 pages in length and deemed too long to easily digest by either the CRC committee or the wider audience it was intended for. The executive lead for the project agreed that the report should be divided into three sections

- Accountability, Funding and Governance
- Research and Knowledge Transfer
- Health and Human Resources

The principal consultants then used the feedback from the CRC meeting to revise the report ensuring committee member's questions and areas of interest were identified in the findings. The final report was released on January 12, 2006.

Appendix B Interview Questions By Stakeholder

Table 1 — Master List of Questions & their Assigned Codes

Question Code		MOH/CEO/CAO	Board	Management	Staff	Partners
1	What would you say are the three most important accomplishments of your health unit over the past year?	■		■	■	
2	What indicators would best demonstrate the effectiveness of your health unit to the community?	■		■	■	
2	How could you best demonstrate the effectiveness of your health unit to the community?			■	■	
2	What indicators would you use for reporting to the public?			■	■	
3	What performance management tools do you think the province should use to monitor how your health unit fulfills its mandate?	■		■		
4	Has this health unit undergone consolidation with another health unit in the past 10 years? Has it amalgamated?	■	■	■		■
4	How did the consolidation improve your ability to provide public health services in the short and long term?	■	■	■		■
5	How did the consolidation detract from your ability to provide public health services in the short and long term?	■	■	■		■
6	What factors should be considered in determining how and whether to reconfigure public health units?	■	■	■		
7	Do you share any services with other health units, for example, communications, risk assessment, epidemiology, or toxicology? What are they?	■	■	■		
8	What works well?	■	■	■	■	
9	What does not work as well?	■	■			
10	What types of services could be shared or configured differently?	■		■		
11	What is behind the MOH vacancies across the province?	■				
12	What are possible solutions for filling these?	■				
13	What do you think might explain this discrepancy?	■		■		
14	What type of public health experience is critical to being able to effectively carry out the role of the CEO/ED?	■				
15	What has your unit done to successfully attract the "best and the brightest" human resources?	■				
16	What needs to be done to increase your health unit's effectiveness in recruiting and retaining staff?	■	■	■		
16	What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?		■			
16	What does your health unit need to do to increase its			■	■	

Table 1 — Master List of Questions & their Assigned Codes						
	Question Code	MOH/CEO/ CAO	Board	Management	Staff	Partners
	effectiveness in recruiting and retaining staff?					
17	What approaches have you found most successful in maintaining or improving morale?	■		■		
18	What technical expertise or skills would you like to augment or add to your health unit? Why?	■		■		
19	How have you prepared for a possible public health crisis requiring support from other health units and agencies and the province?	■		■		
20	What else needs to be put in place?	■		■		
21	What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff?	■	■	■		
21	What strategies have you found to be most successful in strengthening their leadership qualities and skills?		■			
22	What approaches has your health unit put in place to support your staff in connecting with peers within their discipline?	■		■		
22	What approaches to professional development have been put in place?			■		
22	what has your health unit put in place to support you as a staff member in connecting with your peers within your discipline and your professional development?				■	
23	What else could be done in this regard?	■				
23	What else could be done to better support you in networking and professional development?					
24	What types of activities have you found most helpful in strengthening your skills as a leader?	■		■		
25	What else would support you in your leadership role?	■		■		
26	What would adequate research and knowledge transfer capacity, look like at your health unit?	■		■	■	
27	What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?	■		■	■	
27	What is the minimum that the regional grouping needs to provide in order to support your health unit?				■	
27	What collectively should the regional grouping have to provide the minimum support to your work?					
28	What supports for research and knowledge transfer capacity needs to be in place at the provincial level?	■		■	■	
28	What research and knowledge transfer capacity needs to be in place at the provincial level to effectively support your unit?			■	■	
29	What 2-3 improvements in the governance of your health unit would have the greatest impact?	■	■			
30	What do you think should be the key characteristics of such a model?	■	■			
31	What might be the impact of such a change on your Health Unit?	■				
32	Assuming the 75/25 level of funding with either model, what are the advantages ?	■	■			
33	Assuming the 100% level of funding with either model,	■	■	■		

Table 1 — Master List of Questions & their Assigned Codes

	Question Code	MOH/CEO/CAO	Board	Management	Staff	Partners
	what are the advantages ?					
34	Assuming the 75/25 level of funding with either model, what are the disadvantages ?	■	■	■		
35	Assuming the 100% level of funding with either model, what are the disadvantages ?	■	■			
36	What sources of funding do you access in addition to municipalities and the province?	■				
37	How much do you get from each source?	■				
38	For what activities?	■				
39	What proportion is each source of your overall budget?	■				
40	Where do you get your internal Human Resources, IT, legal and finance services?	■				
41	How are they funded?	■				
42	How do you determine appropriate charges for these?	■				
43	What local agencies, public health related or other, do you work with most frequently and most effectively?	■		■	■	
43	What local agencies do you work with most frequently?		■		■	
43	What local agencies do you work with most effectively?				■	
44	We will interview 3 Partners, who should they be?	■				
45	Is there any other key issue that you would like to bring to the attention of the CRC?	■	■	■		
46	What does your Board of Health do well in governing of the work of your health unit?		■			
47	What support from the province would help your Board maximize its effectiveness in governing?		■			
48	If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making?		■			
49	If funding were 100% provincial, what would you see as the municipalities'/regions' role in decision making?		■			
50	What should be put in place to better ensure your health unit is accountable for meeting its program mandate?		■			
51	What role does your Board play in MOH or Senior Staff selection?		■			
52	What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?		■			
53	What support could the province provide with regard to recruitment and retention of senior staff?		■	■		
54	What are the strongest leadership qualities of your health unit's senior staff?		■	■		
54	What are the strongest leadership qualities of the managers and executives in your Health Unit?		■		■	
55	What manager and executive leadership skills would you like to see strengthened in your unit?				■	
56	What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?		■	■		
57	What recommendations would you make on how to ensure Public Health remains a high priority for the public?			■		
58	What municipal or regional staff do you work with most closely?			■		

Table 1 — Master List of Questions & their Assigned Codes

Question Code		MOH/CEO/CAO	Board	Management	Staff	Partners
59	What works well?			■		
60	What could be improved?			■		
61	What does not?			■		
62	What kinds of things would help you to feel more valued?			■	■	
63	What collectively should the regional grouping have to provide the minimum support to your work?			■		
64	Describe a situation where you have felt most valued as an employee of your health unit?			■	■	
65	What would be the best indicators of positive morale and employee satisfaction in a health unit for the both the unit and the province?				■	
66	What are the main factors that keep you and your colleagues working in public heath?			■	■	
67	How could marketing be used to support recruitment and retention and to promote a career in Public Health?				■	
68	What do you have now?				■	
69	Which municipal or regional staff do you work with most closely?				■	
70	What would you like to see improved?				■	
71	Describe the ways in which your organization partners with your local health unit?					■
72	What is working well in your partnerships?					■
73	How are your oganization's needs and interests being addressed through these partnerships?					■
74	How would you describe your organization's communication with your local PHU?					■
75	What would you like to see improved?					■
76	Have you attended a Board of Health meeting in the last year?					■
77	Why or why not?					■
78	What value did you get if you attended?					■
79	What might the impact of such a change be on your municipalities or region?		■			
80	What have you done to successfully attract and retain the "best and brightest" senior staff/MOH?		■			
81	Unused					
82	What are the strongest leadership qualities of your health unit's MOH?		■			
82	What are the strongest leadership qualities of your health unit's CEO?		■			
83	What leadership qualities or skills would you like to see strengthened in your senior staff?		■			

Appendix C Interview Questions by CRC Subcommittee Area of Interest

Table 2 - Interview Questions by CRC Subcommittee Area of Interest	
Question Code	**Question**
Subcommittee	
Accountabilities	
2	What indicators would best demonstrate the effectiveness of your health unit to the community?
2	How could you best demonstrate the effectiveness of your health unit to the community?
2	What indicators would you use for reporting to the public?
3	What performance management tools do you think the province should use to monitor how your health unit fulfills its mandate?
50	What should be put in place to better ensure your health unit is accountable for meeting its program mandate?
Funding	
32	Assuming the 75/25 level of funding with either model, what are the advantages ?
33	Assuming the 100% level of funding with either model, what are the advantages ?
34	Assuming the 75/25 level of funding with either model, what are the disadvantages ?
35	Assuming the 100% level of funding with either model, what are the disadvantages ?
36	What sources of funding do you access in addition to municipalities and the province?
37	How much do you get from each source?
38	For what activities?
39	What proportion is each source of your overall budget?
40	Where do you get your internal Human Resources, IT, legal and finance services?
41	How are they funded?
42	How do you determine appropriate charges for these?
Governance	
4	How did the consolidation improve your ability to provide public health services in the short and long term?
5	How did the consolidation detract from your ability to provide public health services in the short and long term?
6	What factors should be considered in determining how and whether to reconfigure public health units?
7	Do you share any services with other health units, for example, communications, risk assessment, epidemiology, or toxicology? What are they?
8	What works well?
9	What does not work as well?
14	What type of public health experience is critical to being able to effectively carry out the role of the CEO/ED?
19	How have you prepared for a possible public health crisis requiring support from other health units and agencies and the province?
20	What else needs to be put in place?
29	What 2-3 improvements in the governance of your health unit would have the greatest impact?
30	What do you think should be the key characteristics of such a model?
31	What might be the impact of such a change on your Health Unit?
43	What local agencies, public health related or other, do you work with most frequently and most effectively?

Table 2 - Interview Questions by CRC Subcommittee Area of Interest	
Question Code	**Question**
Subcommittee	
43	What local agencies do you work with most frequently?
43	What local agencies do you work with most effectively?
47	What support from the province would help your Board maximize its effectiveness in governing?
48	If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making?
49	If funding were 100% provincial, what would you see as the municipalities'/regions' role in decision making?
58	What municipal or regional staff do you work with most closely?
59	What works well?
60	What could be improved?
61	What does not?
69	Which municipal or regional staff do you work with most closely?
70	What would you like to see improved?
71	Describe the ways in which your organization partners with your local health unit?
72	What is working well in your partnerships?
73	How are your oganization's needs and interests being addressed through these partnerships?
74	How would you describe your organization's communication with your local PHU?
75	What would you like to see improved?
76	Have you attended a Board of Health meeting in the last year?
77	Why or why not?
78	What value did you get if you attended?
79	What might the impact of such a change be on your municipalities or region?
Human Resources	
10	What types of services could be shared or configured differently?
11	What is behind the MOH vacancies across the province?
12	What are possible solutions for filling these?
13	What do you think might explain this discrepancy?
15	What has your unit done to successfully attract the "best and the brightest" human resources?
16	What needs to be done to increase your health unit's effectiveness in recruiting and retaining staff?
16	What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?
16	What does your health unit need to do to increase its effectiveness in recruiting and retaining staff?
17	What approaches have you found most successful in maintaining or improving morale?
18	What technical expertise or skills would you like to augment or add to your health unit? Why?
21	What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff?
21	What strategies have you found to be most successful in strengthening their leadership qualities and skills?
22	What approaches has your health unit put in place to support your staff in connecting with peers within their discipline?
22	What approaches to professional development have been put in place?
22	What has your health unit put in place to support you as a staff member in connecting with your peers within your discipline and your professional development?
23	What else could be done in this regard?

Table 2 - Interview Questions by CRC Subcommittee Area of Interest

Question Code	Question
Subcommittee	
23	What else could be done to better support you in networking and professional development?
24	What types of activities have you found most helpful in strengthening your skills as a leader?
25	What else would support you in your leadership role?
51	What role does your Board play in MOH or Senior Staff selection?
52	What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?
53	What support could the province provide with regard to recruitment and retention of senior staff?
54	What are the strongest leadership qualities of your health unit's senior staff?
54	What are the strongest leadership qualities of the managers and executives in your Health Unit?
55	What manager and executive leadership skills would you like to see strengthened in your unit?
56	What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?
57	What recommendations would you make on how to ensure Public Health remains a high priority for the public?
62	What kinds of things would help you to feel more valued?
64	Describe a situation where you have felt most valued as an employee of your health unit?
65	What would be the best indicators of positive morale and employee satisfaction in a health unit for the both the unit and the province?
66	What are the main factors that keep you and your colleagues working in public heath?
67	How could marketing be used to support recruitment and retention and to promote a career in Public Health?
68	What do you have now?
80	What have you done to successfully attract and retain the "best and brightest" senior staff/MOH?
82	What are the strongest leadership qualities of your health unit's MOH?
82	What are the strongest leadership qualities of your health unit's CEO?
83	What leadership qualities or skills would you like to see strengthened in your senior staff?
Research and Knowledge Transfer	
45	Is there any other key issue that you would like to bring to the attention of the CRC?
26	What would adequate research and knowledge transfer capacity, look like at your health unit?
27	What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?
27	What is the minimum that the regional grouping needs to provide in order to support your health unit?
28	What supports for research and knowledge transfer capacity needs to be in place at the provincial level?
28	What research and knowledge transfer capacity needs to be in place at the provincial level to effectively support your unit?
63	What collectively should the regional grouping have to provide the minimum support to your work?

Appendix D Public Health Unit Demographics Summary

PHU Demographics Summary

PHU Governance Structure

Table 3 - Autonomous Vs. Integrated PHU Governance Summary	
PHU GOVERNANCE STRUCTURE	
NUMBER OF AUTONOMOUS PHU'S	25
NUMBER OF ALIGNED PHU'S	11

PHU Governance Structure	
Number of Autonomous PHU's	25
Number of Aigned PHU's	11

PHU Geographic Summary

Table 4 - Regional Summary	
REGIONAL SUMMARY	
CENTRALEAST	7
CENTRALWEST	7
EASTERN	6
NORTHEAST	5
NORTHWEST	2
SOUTHWEST	9

PHU Service Population

Table 5 - PHU Population Served Size Summary	
SIZE	#
POPULATION SERVED	
<135,000K	15
135K – 299K	9
300K – 599K	8
>599K	4

PHU Leadership Summary

Table 6 - PHU Leadership Summary

Table 6 - PHU Leadership Summary	
Number of Vacant MOH Positions:	1
Number of MOH's interviewed:	27
Number of Acting MOH's interviewed:	8
Both MOH & CEO	21

Appendix E PHU Interviews and Focus Groups Summary

Staff Focus Groups

Table 7 — Staff Focus Group Roles

ROLE	# OF PARTICIPANTS
HEALTH PROMOTION / PLANNING / DEVELOPMENT	51
NURSE	204
PROGRAM SUPERVISOR/COORD/ASSISTANT/ SUPPORT	22
HUMAN RESOURCE ASSOCIATE / RESOURCE COORDINATOR / PROJECT SPECIALIST / COMMUNITY LIAISON	33
DENTAL HYGIENIST	21
DENTAL HEALTH	11
SECRETARY/ADMIN ASSISTANT/CLERICAL	58
COMMUNICATIONS / MARKETING / MEDIA	17
SPEECH/LANGUAGE PATHOLOGIST	4
EPIDEMIOLOGIST	10
DIETICIAN/NUTRITIONIST	28
HEALTH INSPECTOR	73
ANALYST (HEALTH INFORMATION/ENVIRONMENTAL/ POLICY)	7
SYSTEMS SUPPORT TECHNICIAN / IT / LIBRARY	13
CHILD & YOUTH HEALTH / BABY & PARENT PROGRAM (HEALTH BABIES)	10
ACCOUNTING AND FINANCE	6
TOBACCO	4
FAMILY VISITOR / HEALTH EDUCATOR / PERSONAL SUPPORT WORKER / FAMILY HEALTH WORKER	13

Staff Focus Group Years of Service

Table 8 — Staff Focus Group Years of Service

Years of Service	
Less than1 year	11
1-5 years	192
6-10 years	119
11-15 years	79
16-20 years	68
20+ years	116
TOTAL	585

Management Focus Groups

Table 9 — Management Focus Group Roles	
ROLE	# OF PARTICIPANTS
ADMIN & HUMAN RESOURCES	38
DENTAL PROGRAMS	18
FINANCE / ACCOUNTING / COMPTROLLER	8
TOBACCO & ADDICTION PROGRAMS	9
SEXUAL HEALTH	11
COMMUNICABLE DISEASE & INFECTIOUS DISEASE	19
EPIDEMIOLOGIST	20
CHRONIC DISEASE/INJURY PREVENTION	14
PROGRAM SUPERVISOR/MANAGER/DIRECTOR *	52
HEALTH DETERMINANTS / EVALUATION / PLANNING / POLICY ANALYST	15
FAMILY HEALTH AND COMMUNITY RESOURCES	32
PUBLIC HEALTH LIBRARIAN / LIBRARY SERVICES	2
INFORMATION SPECIALIST / RECORDS MANAGEMENT / IT	7
ASSOCIATE/ACTING MOH/ACTING BAO / ASSOCIATE COMMISSIONER	12
IMMUNIZATION & VACCINE PREVENTABLE DISEASE	7
ENVIRONMENTAL HEALTH & LIFESTYLE RESOURCES	48
MARKETING/COMMUNICATIONS/MEDIA RELATIONS	8
EARLY CHILD DEVELOPMENT / HEALTHY BABY	9
CENTRAL RESOURCES	2
POPULATION HEALTH	5
CLINICAL SERVICES	10
HEALTH PROMOTION	21
HEALTH PROTECTION	14
HEALTH INSPECTION	6
CHILD & YOUTH SERVICES & HEALTH	8
PUBLIC HEALTH NURSING & NUTRITION	12
QUALITY IMPROVEMENT / CONTINUOUS IMPROVEMENT & STRATEGIC PLANNING	8
CORPORATE SERVICES / DIRECTOR, PUBLIC HEALTH /LEGAL COUNSEL	12
PHRED	3

- Note: As their role, many just indicated "Program Manager", "Program Supervisor", Program Director" or just "Manager" with no further clarification to classify them by – they are incorporated here.

Management Focus Groups Years of Service

Table 10 — Management Focus Group Years of Service	
MANAGEMENT FOCUS GROUP YEARS OF SERVICE	
LESS THAN 1 YEAR	9
1-5 YEARS	86
6-10 YEARS	74
11-15 YEARS	61
16-20 YEARS	56
20+ YEARS	144
TOTAL	430

Partner Interviews

Table 11 — Partner Interview Demographics	
PARTNER INTERVIEW DEMOGRAPHICS	
SCHOOLS	16
HOSPITALS	15
COMMUNITY CARE/MEDICAL COMPANIES	28
CHARITIES	4
OTHER	15
TOTAL	78

Appendix F Province of Ontario Public Health Unit Demographic Data

Table 12 - Detailed PHU Demographics					
Locations	Autonomous/ Aligned	Size	Region	Leadership	MOH Status
Algoma	Autonomous	>135,000	Northeast	Same CEO/MOH	Filled
Brant	Autonomous	>135,000	Central west	Different CEO/MOH	Acting
Chatham-Kent	Autonomous	>135,000	Southwest	Different CEO/MOH	Acting
Durham	Aligned	300,000 - 599,999	Central East	Different CEO/MOH	Filled
Eastern Ontario	Autonomous	135,000 - 299,999	Eastern	Same CEO/MOH	Filled
Elgin-St. Thomas	Autonomous	>135,000	Southwest	Different CEO/MOH	Acting
Grey Bruce	Autonomous	135,000 - 299,999	Southwest	Same CEO/MOH	Filled
Haldimand-Norfolk	Aligned	>135,000	Central west	Different CEO/MOH	Acting
Halliburton, Kawartha, Pine Ridge	Autonomous	135,000 - 299,999	Central East	Same CEO/MOH	Filled
Halton	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
Hamilton	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
Hastings & Prince Edward Counties	Autonomous	135,000 - 299,999	Eastern	Same CEO/MOH	Filled
Huron	Autonomous	>135,000	Southwest	Different CEO/MOH	Filled
Kingston-Frontenac	Autonomous	135,000 - 299,999	Eastern	Same CEO/MOH	Filled
Lambton	Autonomous	>135,000	Southwest	Different CEO/MOH	Filled
Leeds, Grenville & Lanark District	Autonomous	135,000 - 299,999	Eastern	Different CEO/MOH	Acting
Middlesex-London	Autonomous	300,000 - 599,999	Southwest	Same CEO/MOH	Filled
Niagara	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
North Bay Parry Sound	Autonomous	>135,000	Northeast	Same CEO/MOH	Filled
Northwestern (Kenora)	Autonomous	>135,000	Northwest	Same CEO/MOH	Filled
Ottawa	Aligned	<599,999	Eastern	Different CEO/MOH	Acting
Oxford	Aligned	>135,000	Southwest	Different CEO/MOH	Acting
Peel	Aligned	<599,999	Central East	Different CEO/MOH	Filled
Perth	Autonomous	>135,000	Southwest	Same CEO/MOH	Filled
Peterborough	Autonomous	>135,000	Central East	Same CEO/MOH	Filled
Porcupine	Autonomous	>135,000	Northeast	Different CEO/MOH	Filled
Renfrew	Autonomous	>135,000	Eastern	Same CEO/MOH	Filled
Simcoe Muskoka	Autonomous	300,000 - 599,999	Central East	Same CEO/MOH	Filled
Sudbury	Autonomous	135,000 - 299,999	Northeast	Same CEO/MOH	Filled
Thunder Bay	Autonomous	135,000 - 299,999	Northwest	Different CEO/MOH	Acting
Timiskaming	Autonomous	>135,000	Northeast	Different CEO/MOH	Acting
Toronto	Aligned	<599,999	Central East	Different CEO/MOH	Filled
Waterloo	Aligned	300,000 - 599,999	Central west	Different CEO/MOH	Filled
Wellington-Dufferin-Guelph	Autonomous	135,000 - 299,999	Central west	Same CEO/MOH	Filled
Windsor-Essex	Autonomous	300,000 - 599,999	Southwest	Same CEO/MOH	Filled
York region	Aligned	<599,999	Central East	Different CEO/MOH	Filled

Appendix G Sample Interview Form

Capacity Review Committee
Board of Health On-site Interview
Research Protocol Script

Greetings & Introductions

- Thank you, on behalf of the Capacity Review Committee, for giving us your time for this interview.

- As you are aware, the Capacity Review Committee was established to meet objectives set out in *Operation Health Protection.* The mandate is to "review the capacity of local public health units and how public health services and programs are delivered across the province. It will advise the government on options to improve the local public health unit systems." The CRC will deliver its report to Ontario's Chief Medical Officer of Health, Sheela Basrur, in early 2006.

- Phase 1 of the Committee's work - surveys of health units, health unit staff and Board members - has been completed and the CRC's interim report is forthcoming.

- **Phase 2 entails a series of interviews and focus groups with health unit staff, Board members and local partners *to probe* on specific issues identified by its subcommittees given the survey results and their other research activities.**

- The Capacity Review Committee has engaged Starfield Consulting to carry out those interviews, focus groups and roundtable discussions and that is why I'm here with you today.

The information sought from you

- We are interviewing members of each Board of Health using the questions developed by the five CRC Sub-Committees and the CRC in consultation with Starfield.

- **The questions pertain to the key issues that the CRC Committees are now pursuing and where they need your individual or collective input or opinions.**

- The CRC recommendations and thus the questions are for the most part focused on the overall Ontario Public Health System, although we acknowledge that your experience of your Unit contributes to your perception of the overall system. There are a few questions where information specific to your health unit would assist the work of the committees.

What will be done with the results?

- **Your answers to these questions will be combined with those of other Board of Health members. Starfield Consulting will synthesise the information** gathered from these interviews and focus groups into a report to be presented to the CRC. The CRC will present a final report to the MOHLTC in early 2006 which will include the findings from these consultations.

- We will be looking for patterns in the responses to the questions as well as strong individual statements.

- Neither your name nor your health unit will be mentioned in relation to your specific answers without your consent.

Confidentiality

- We and the Ministry assure you that **all information gathered will be held in the strictest of confidence.** We (Starfield) will document and store the input to the consultations, and this information will be used for the purposes of this review only. As previously stated, no information will be released or printed that would identify any person by name.

- Your participation today is voluntary

Research Protocol

Timing: The Group Interview should last 1.5 hours

Context Questions – Let's start with some questions about you?

- What are your **roles** on the board?

- **How** did you become a board member?
  - Election (Are you a municipal or regional council member?)
  - Municipal Appointment
  - Provincial Appointment

- It is our understanding that your health unit is a _____ is that correct?
  1. City or Single Tier Health Department
  2. Regional or Upper Tier Health Department
  3. County or District Health Unit

- Is your Board **autonomous** of the city, region or county/district structure or is the **board aligned or embedded** in those structures.

Interview Questions

Context & Question	Com
1. GOVERNANCE STRUCTURE & EFFECTIVENESS	
a. What does your Board of Health do well in governing of the work of your health unit?	
Different types of improvements in public health governance have been suggested as part of the capacity review. For example: • selection of board members based on specified expertise • more orientation of Board members • standardized Board member recruitment practices • greater visibility of the board ***b. What 2-3 improvements in the governance of your health unit would have the greatest impact?***	Gov
c. What support from the province would help your Board maximize its effectiveness in governing?	Gov
The Capacity Review committee is exploring the option of moving, over time, to a more uniform provincial model for governance of Public Health which would differ from the current ones. ***d. What do you think should be the key characteristics of such a model?***	Gov
e. Autonomous Board: What might the impact of such a change be on your municipalities? ***e. Aligned Board: What might the impact of such a change be on your municipality or region?***	Gov
2. FUNDING AND ACCOUNTABILITY	
The CRC is currently considering two possible models for funding health units (75/25 cost sharing, and 100% provincial). ***a. Assuming the same level of funding with either model, what are the advantages and disadvantages of each approach?***	Fund
b. If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making? ***c. If funding were 100% provincial, what would you see as the municipalities'/region's role in decision making?***	Gov

Submissions to the capacity review have identified that existing accountability structures and tools are inadequate. ***d. What should be put in place to better ensure your health unit is accountable for meeting its program mandate?***	Acnt
3. CONFIGURATION	
a. Has this health unit undergone consolidation with another health unit in the past 10 years? [prompt – has it amalgamated]?	
(only for health units who have been reconfigured – **Toronto, Simcoe-Muskoka, North Bay-Parry Sound, & Grey Bruce**) ***b. How did the consolidation improve your ability to provide public health services in the short and long term?*** ***c. How did the consolidation detract from your ability to provide public health services in the short and long term?***	Gov
The Walker report recommended reconfiguring the public health system. ***d. What factors should be considered in determining how and whether to reconfigure health units?***	Gov
e. Do you share any services with other health units for example, communications, risk assessment, epidemiology, or toxicology? ***f. What works well?*** ***g. What does not work as well?***	Gov
4. RECRUITMENT AND RETENTION	
a. What role does your Board play in MOH or Senior Staff selection?	
b. What have you done to successfully attract and retain the "best and brightest" senior staff? MOH?	HR
(For health units with an acting MOH.) ***c. What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?***	HR
d. What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?	HR
e. What support could the province provide with regard to recruitment and retention of senior staff?	HR

5. LEADERSHIP	
a. What are the strongest leadership qualities of your health unit's senior staff? MOH? CEO?	HR
b. What leadership qualities or skills would you like to see strengthened in your senior staff?	HR
c. What strategies have you found to be most successful in strengthening their leadership qualities and skills?	HR
d. What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?	HR
6. OTHER	
Is there any other key issue that you would like to bring to the attention of the CRC?	

Closing

Given the short timeframe for initiative and our desire to ensure accuracy, we want to confirm what we have heard at this point. So, I will quickly report back to you what I have heard and recorded in your responses to each section to confirm that I have understood the direction of your comments.

We will be gathering information throughout this month and then submit our report in December.

The CRC is to complete its report in early 2006.

Thank you for your time and active participation.

Appendix H Sample On-site Agenda and Small Group Guide

STARFIELD CONSULTING

Leadership & Professional Development

Please self-organize your small group discussion, answer the questions together and prepare a flip chart summary of your response to each question. You will be asked to post the flip charts for review by the group at this session. During your brainstorm or discussion please record your differing views and also clearly mark where you do have agreement in your small group.

A. Decide on Roles

As a group, decide who will play the following roles for this small group work:

Table Group Roles:	
Facilitator:	Initiates group discussion, ensuring that the task is accomplished and that everyone has the opportunity to speak.
Time Keeper:	Keeps track of time given to complete the task at hand. Let the group know how much time is left for discussion. You will have 15 minutes.
Recorder:	Legibly records group responses to the questions on flip chart.
Reporter:	Reports back to the whole group when called upon.

B. Questions

Ensuing effective leadership and strong professional skill levels has been identified as a challenge facing public health.

a. **What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff? What approaches to professional development have been put in place?**

b. **What approaches has your health unit put in place to support the staff in connecting with peers within their discipline?**

c. **What else could be done in this regard?**

d. **What types of activities have you found helpful in strengthening your skills as a leader?**

e. **What else would support you in your leadership role**

Appendix I Sample Coding Template Tool

MOH/CEO Template for Entering Themes

Respondent: MOH/CEO (1)

Question 1.b What indicators would best demonstrate the effectiveness of your health unit to the community?

Cross Reference Question (2)

Location Code	Theme	Examples, Quotes and Keywords

Appendix J Data Analysis Plan

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
1	MOH 1a Staff 5a Mgmt 1a	***What are three-five most important accomplishments of this last year?*** General analysis based on interview notes Include quotes and dramatic examples
	Governance	
46	Board 1a	***What does your Board of Health do well in governing of the work of your health unit?*** General analysis based on interview notes Include quotes and dramatic examples
29	MOH 6a Board 1b ***Overall Governance***	***What 2-3 improvements in the governance of your health unit would have the greatest impact?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
47	Board 1c ***Overall Governance***	***What support from the province would help your Board maximize its effectiveness in governing?*** Extract themes and code Standard demographic run First & Second levels of analysis
30	MOH 6b Board 1d ***Governance Model***	***What do you think should be the key characteristics of such a model?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
31	MOH 6c ***Governance Model***	***What might be the impact of such a change on your Health Unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
79	Board 1e ***Governance Model***	***What might the impact of such a change be on your municipalities or region?*** Extract themes and code Standard demographic run First & Second levels of analysis
48	Board 2b ***Funding***	***If funding were 75/25 cost sharing, what would you see as the municipalities'/region's role in decision making?*** Extract themes and code Standard demographic run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
49	Board 2c ***Funding***	***If funding were 100% provincial, what would you see as the municipalities'/regions' role in decision making?*** Extract themes and code Standard demographic run First & Second levels of analysis
6	MOH 2d Board 3d Mgmt 2d ***Configuration***	***What factors should be considered in determining how and whether to reconfigure Health Units?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
4 & 5	MOH 2a, 2b Board 3a, 3b, 3c Mgmt 2a, 2b Partner 3a, 3b, 3c ***Configuration***	***Has this Health Unit undergone consolidation with another Health Unit in the last 10 years?*** ***How did the consolidation improve your ability to provide public health services in the short and long term?*** ***How did the consolidation detract from your ability to provide public health services in the short and long term?*** General analysis based on interview notes Extract themes
7	MOH 2d Board 3e Mgmt 2d ***Shared Services***	***Do you share any services with other health units, for example, communications, risk assessment, epidemiology, or toxicology?*** ***What are they?*** Extract themes and code Standard demographic run First & Second levels of analysis
8	MOH 2e Board 3f Mgmt 2e ***Shared Services***	***What works well?*** General analysis based on interview notes
9 & 61	MOH 2f Board 3g Mgmt 2f ***Shared Services***	***What does not work as well? OR What does not?*** General analysis based on interview notes
10	MOH 2g Mgmt 2g ***Shared Services***	***What types of services could be shared or configured differently?*** Extract themes and code Standard demographic run First & Second levels of analysis
43	MOH 8a Staff 5c Mgmt 1e ***Partnering***	***What local agencies, public health related or other, do you work with most frequently and most effectively?*** List agencies in order of frequency mentioned General analysis based on interview notes Responses for most frequently and effectively were very poor (not answered by many)
58, 59, 60	Staff 5d Mgmt 1f ***Partnering***	***What municipal or regional staff do you work with most closely?*** ***What works well?*** ***What could be improved?*** List agencies in order of frequency mentioned General analysis based on interview notes Responses for works well and could be improved were very poor (not answered by many)

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
44	MOH 8b ***Partnering***	***We will interview 3 Partners, who should they be?*** Report demographics of partners interviewed
71	Partner 1a ***Partnering***	***Describe the ways in which your organization partners with your local health unit?*** General analysis based on interview notes
72	Partner 2a ***Partnering***	***What is working well in your partnerships?*** General analysis based on interview notes
73	Partner 2b ***Partnering***	***How are your organization's needs and interests being addressed through these partnerships?*** General analysis based on interview notes
74	Partner 2c ***Partnering***	***How would you describe your organization's communication with your local PHU?*** General analysis based on interview notes
75	Partner 2d ***Partnering***	***What would you like to see improved?*** General analysis based on interview notes
76, 77, 78	Partner 4a, 4b ***Partnering***	***Have you attended a Board of Health meeting in the last year?*** ***Why or why not?*** ***What value did you get if you attended?*** General analysis based on interview notes
19	MOH 3h Mgmt 3g ***Surge Capacity***	***How have you prepared for a possible public health crisis requiring support from other health units and agencies and the province?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
20	MOH 3i Mgmt 3h ***Surge Capacity***	***What else needs to be put in place?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
14	MOH 3c ***Organization Structure***	***What type of public health experience is critical to being able to effectively carry out the role of the CEO/ED?*** Extract themes and code Standard demographic run First & Second levels of analysis
	Accountability / Performance Management	
2	MOH 1b Staff 5b Mgmt 1b ***Performance Management***	***What indicators would best demonstrate the effectiveness of your health unit to the community?*** ***How could you best demonstrate the effectiveness of your health unit to the community?*** ***What indicators would you use for reporting to the public?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
50	Board 2d ***Performance Management***	***What should be put in place to better ensure your health unit is accountable for meeting its program mandate?*** Extract themes and code Standard demographic run First & Second levels of analysis
3	MOH 1c Mgmt 1c ***Performance Management***	***What performance management tools do you think the province should use to monitor how your health unit fulfills its mandate?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
	Funding	
32, 33, 34, 35	MOH 7a Board 2a ***Funding***	***Assuming the same level of funding, what are the advantages of 75/25?*** ***Assuming the same level of funding, what are the advantages of 100%?*** ***Assuming the same level of funding, what are the disadvantages of 75/25?*** ***Assuming the same level of funding, what are the disadvantages of 100?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
36, 37, 38, 39, 40, 41, 42	MOH 7b, 7c ***Funding***	***What sources of funding do you access in addition to municipalities and the province?*** ***How much do you get from each source?*** ***For what activities?*** ***What proportion is each source of your overall budget?*** ***Where do you get your internal Human Resources, IT, legal and finance services?*** ***How are they funded?*** ***How do you determine appropriate charges for these?*** High level summary (actual responses handed into subcommittee)
	Research and Knowledge Transfer	
26	MOH 5a Staff 4a Mgmt 5a ***Research and Knowledge Transfer***	***What would adequate research and knowledge transfer capacity, look like at your health unit?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
68	MOH 5a Staff 4a Mgmt 5a ***Research and Knowledge Transfer***	***What do you have now?*** This question was mostly ignored as it was asked within previous question –not able to report on it

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27, 63	MOH 5b Staff 4b Mgmt 5b ***Research and Knowledge Transfer***	***What would adequate research and knowledge transfer capacity look like at the regional Ministry health planning level?*** ***What is the minimum that the regional grouping needs to provide in order to support your health unit?*** ***What collectively should the regional grouping have to provide the minimum support to your work?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
28	MOH 5c Staff 4c Mgmt 5c ***Research and Knowledge Transfer***	***What supports for research and knowledge transfer capacity needs to be in place at the provincial level?*** ***What research and knowledge transfer capacity needs to be in place at the provincial level to effectively support your unit?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
	Human Resources	
51	Board 4a ***MOH and Senior Staff Recruitment and Retention***	***What role does your Board play in MOH or Senior Staff selection?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
11	MOH 3a ***MOH and Senior Staff Recruitment and Retention***	***What is behind the MOH vacancies across the province?*** Extract themes and code Standard demographic run First & Second levels of analysis
12	MOH 3a ***MOH and Senior Staff Recruitment and Retention***	***What are possible solutions for filling these?*** Extract themes and code Standard demographic run First & Second levels of analysis
13	MOH 3b ***Recruitment and Retention***	What do you think might explain this discrepancy? Extract themes and code Standard demographic run First & Second levels of analysis
52	Board 4c ***MOH and Senior Staff Recruitment and Retention***	***What are the main reasons why your health unit has an acting MOH rather than a permanent MOH?*** Extract themes and code Standard demographic run First & Second levels of analysis
53	Board 4e ***MOH and Senior Staff Recruitment and Retention***	***What support could the province provide with regard to recruitment and retention of senior staff?*** Extract themes and code Standard demographic run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
82	Board 5a ***Leadership***	***What are the strongest leadership qualities of your health unit's senior staff? MOH? CEO?*** Extract themes and code Standard demographic run First & Second levels of analysis
54	Staff 3a ***Leadership***	***What are the strongest leadership qualities of the managers and executives in your Health Unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
83	Board 5b ***Leadership***	***What leadership qualities or skills would you like to see strengthened in your senior staff?*** Extract themes and code Standard demographic run First & Second levels of analysis
55	Staff 3b ***Leadership***	***What manager and executive leadership skills would you like to see strengthened in your unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
56	Board 5d ***Leadership***	***What plans do you have or would you like to see implemented to strengthen leadership in your Health Unit?*** Extract themes and code Standard demographic run First & Second levels of analysis
64	Staff 1a Mgmt 3a ***Being & Feeling Valued***	***Describe a situation where you have felt most valued as an employee of your health unit?*** General analysis based on interview notes Include quotes and variety of examples
62	Staff 1b Mgmt 3b ***Being & Feeling Valued***	***What kinds of things would help you to feel more valued?*** Extract themes and code Standard demographic run First & Second levels of analysis
65	Staff 1c ***Being & Feeling Valued***	***What would be the best indicators of positive morale and employee satisfaction in a health unit for the both the unit and the province?*** Extract themes and code Standard demographic run First & Second levels of analysis
17	MOH 3f ***Being & Feeling Valued***	***What approaches have you found most successful in maintaining or improving morale?*** Extract themes and code Standard demographic run First & Second levels of analysis
66	Staff 2a Mgmt 3c ***Recruitment and Retention***	***What are the main factors that keep you and your colleagues working in public heath?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
80	Board 4b ***Recruitment and Retention***	***What have you done to successfully attract and retain the "best and brightest" senior staff/MOH?*** Extract themes and code Standard demographic run First & Second levels of analysis
15	MOH 3d ***Recruitment and Retention***	***What has your unit done to successfully attract the "best and the brightest" human resources?*** Extract themes and code Standard demographic run First & Second levels of analysis
81	Board 4d ***Recruitment and Retention***	***What additional things do you believe your Board needs to do to support better recruitment and retention of senior staff?*** Extract themes and code Standard demographic run First & Second levels of analysis
16	MOH 3e Staff 2b Mgmt 3e ***Recruitment and Retention***	***What needs to be done to increase your health unit's effectiveness in recruiting and retaining staff?*** ***What does your health unit need to do to increase its effectiveness in recruiting and retaining staff?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
18	MOH 3g Mgmt 3f ***Recruitment and Retention***	***What technical expertise or skills would you like to augment or add to your health unit? Why?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
67	Staff 2c ***Recruitment and Retention / Public Profile***	***How could marketing be used to support recruitment and retention and to promote a career in Public Health?*** Extract themes and code Standard demographic run First & Second levels of analysis
57	Mgmt 1d ***Public Profile***	***What recommendations would you make on how to ensure Public Health remains a high priority for the public?*** Extract themes and code Standard demographic run First & Second levels of analysis
21	MOH 4a Board 5c Mgmt 4a ***Professional Development***	***What types of activities have you found helpful in strengthening the skills and abilities of your health unit's management and staff?*** ***What strategies have you found to be most successful in strengthening their leadership qualities and skills?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis

Question Code	Question number(s) on Protocol(s)	Analysis Approach per Question
22, 23	MOH 4b, 4c Staff 3c, 3d Mgmt 4b, 4c ***Professional Development***	***What approaches has your health unit put in place to support your staff in connecting with peers within their discipline?*** ***What approaches to professional development have been put in place?*** ***What has your health unit put in place to support you as a staff member in connecting with your peers within your discipline and your professional development?*** ***What else could be done in this regard? What else could be done to better support you in networking and professional development?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
24	MOH 4d Mgmt 4d ***Professional Development***	***What types of activities have you found most helpful in strengthening your skills as a leader?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
25	MOH 4e Mgmt 4e ***Professional Development***	***What else would support you in your leadership role?*** Extract themes and code Standard demographic run Respondent run First & Second levels of analysis
45		***Is there any other key issue that you would like to bring to the attention of the CRC?*** General analysis based on interview notes